General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 21-23 Clockhouse Lane, Collier Row, ROMFORD, Essex, RM5 3PH

Pharmacy reference: 1031348

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

This is a community pharmacy located in a parade of shops on a main road. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also provides flu and pneumococcal vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with its services. The pharmacy is good at recording and reviewing any mistakes that happen during the dispensing process. It learns from these to help make the services safer for people to use. It largely keeps all the records it needs by law. And it asks people who use the pharmacy for their views. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe.

Inspector's evidence

Standard Operating Procedures (SOPs) were up to date. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs. The pharmacy team had completed audits for some of the SOPs.

Near misses were brought to the attention of the team member who had made the mistake and recorded on a near miss log by whoever was checking the prescription. A brief review of the near-misses was completed by the pharmacist on Fridays. As a result of a past review the team had highlighted the area where eyedrops were stored and separated some eyedrops to ensure mistakes did not reoccur. The RP said that changes were also made when the team spotted something that had the potential of being an error.

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. Learning from incidents was shared with all branches via the superintendent's Professional Standards Bulletin. The RP said that a separate record was made if an incident involved controlled drugs (CDs). As a result of an incident that had occurred the RP had stuck notes in the dispensary reminding pharmacists not to self-check and said that he ensured he took extra time to check when it was particularly busy such as before the Christmas holidays.

Patient safety reviews were completed on a monthly basis as part of which the team reviewed all recorded near misses and incidents. And went through the records to identify any patterns. Previous reviews had identified the people were commonly mis-picking the wrong form such as ramipril capsules and tablets.

The pharmacy had a complaints procedure in place and details of the customer care team were printed at the back of the receipts. Annual patient satisfaction surveys were also carried out. The team also handed out patient survey cards which could be completed online at any time with feedback sent to head office. The team were measured on this weekly in terms of the number of responses received. The RP would try and resolve complaints which were not involving him in store. Otherwise they were triaged to the area manager. The RP said that as a result of a complaint on miscommunication, he had asked a team member to watch a video made by Boots to help colleagues understand how people were feeling, being empathetic and not misunderstanding their behaviour.

The correct responsible pharmacist (RP) notice was displayed. One of the team members was not fully aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. Records for emergency supplies, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. Although, the pharmacist had signed

out in advance in the RP record. Records for private prescriptions were generally well maintained but some of the entries observed did not have the correct prescriber details or the correct date on which the prescription had been issued.

CD balance checks were carried out on a weekly basis. A random check of CD medicines complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received. Assembled prescriptions were stored on a retrieval system and were not visible to people. An information governance policy was in place and each year the team were required to complete training on the e-Learning system. The team had also completed an e-learning module on the General Data Protection Regulation (GDPR). The dispensary team had individual smartcards and passwords to access the NHS electronic systems. The RP was due to arrange for the students to obtain their smartcards. The RP had displayed a poster on the wall for GDPR to show team members the areas which impacted retail pharmacy. Both pharmacists had access to Summary Care Records and consent was gained verbally.

The team had completed safeguarding training on the e-learning system; in addition to this the RP and accuracy checking technician (ACT) had also completed the level 2 training. Details for the local safeguarding boards were available and the team could describe where this could be found. The team would report any concerns to the RP. The RP also had the direct email address for a care worker of a vulnerable person so that he could communicate with her directly if there were any issues.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and team members work well together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the store manager (regular pharmacist), a dispenser (trainee technician), a pharmacy student and another dispenser. The pharmacy also had an ACT who was on holiday at the time of the inspection. All team members who worked in the store were trained to work in the dispensary so that they could help if the shop was quiet. The RP said that holidays were either covered by an area relief or the team covered shifts.

The RP did not feel that there were enough team members for the services provided by the pharmacy. He said that the budget for the pharmacy was lower as it was a local pharmacy. He had raised this with the area managers but said it was not their decision. The team organised the workload to ensure that they did not fall behind. The pharmacy student was working extra shifts to cover the ACT. The RP said that had the student not been available the pharmacy would have fallen behind. At the time of the inspection the pharmacy was on track with their dispensing and were completing tasks in a timely manner. One of the dispensers also helped in the main dispensary before moving to prepare the compliance packs. If there was not much retail work then the dispenser who covered the shop floor could also help in the pharmacy.

Staff performance was managed formally with reviews carried out, the RP sat with team members and discussed targets. The RP also gave 'in the moment' feedback so that everyone was aware of how they were performing and had the opportunity to improve. The RP also asked team members to give him feedback. The pharmacy student counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She would refer to the RP when faced with a request for multiple sales and if she was unsure.

The team were provided with regular training modules on e-learning which covered a range of different topics and areas. The team members could take time in store to complete their training. Team members on formal training courses were given study time on Saturday as it was less busy.

'Let’s Connect' events were attended by the pharmacists and technicians so that they could share learning with teams in other stores. The previous event had covered mistakes and delegates had been shown videos on mind perception and the impact on dispensing. The RP said that the event also enabled people to provide feedback to managers.

As well as receiving the monthly Professional Standards bulletins the team received alerts on Boots live (the company intranet). The RP attended weekly area conference calls and cascaded information to the team. The team discussed things as they came up. The RP said that he would speak to the team during the weekdays and brief people who worked on Saturday separately. The RP received additional pharmacist cover once a month. The team also communicated over mobile messaging applications.

Targets were in place for the services provided and the store had a target to deliver 400 medicine use

reviews (MURs) each year. The team said that there was no pressure to meet the targets. The RP said he would provide services where he could. Targets did not affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was in the main clean and suitable for the provision of healthcare. The dispensary was narrow. Workbench space had been roughly allocated and the team tried to keep dispensing and checking areas clean. Shelves were used to store assembled prescriptions waiting to be checked so that workbenches were kept clear and so that prescriptions could be easily located. Multi-compartment compliance packs were prepared in a dedicated room. Cleaning was done by the team with a rota in place. Medicines were arranged neatly on pull-out shelves and separated with clear dividers, to prevent the mixing of various drugs, strengths and forms. A clean sink was available.

There was a clearly signposted consultation room available for patients to have private conversations. The room was kept locked at all times. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it generally manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful and give advice to people about where they can get support. They also make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street with a ramp and power assisted doors. There was easy access to the medicines counter. The pharmacy had the facilities to print large print labels. And it had a hearing loop. One of the team members was multilingual. The team would use an online translation service if someone did not speak English.

The RP said that the Medicines Use Reviews had the most impact on the local population. He said the consultation enabled him to find out if people knew about their medicines or if they were not taking them correctly. He explained that in a review he had found a person who had misunderstood and thought that they only needed to take their medication when needed. And he had been able to use the opportunity to explain to them why they needed to take their medication. The person had also been concerned about their weight after being discharged from hospital and the RP had referred them to one of his colleagues who was part of Slimming World.

As the pharmacy was a Healthy Living Pharmacy, the team asked people for feedback on what they would like to see offered in the pharmacy and how the pharmacy team could help. The RP said the pharmacy had run a campaign on children's mental health as well as dementia. The pharmacy had a folder with information on dementia to help the team. The RP said that he was also a foster carer and had an interest in children's mental health. He added that it was one of the campaigns where he had to reorder more leaflets due to the popularity. Most people were taking the leaflets out of interest but no one had approached the RP for more information.

The pharmacy had an established workflow in place. Prescriptions were dispensed by the dispensers and checked by the pharmacists or ACT. A large proportion of prescriptions were received electronically. People initiated the order of their repeat prescriptions from the surgery. These prescriptions were processed using the Webscript system. This helped to arrange the workflow. Prescriptions were annotated with the date that they were due to be collected or marked with a 'C' if someone had ordered directly from the surgery. Pharmacist Information Forms (PIF) forms were used by dispensers to pass on information to the pharmacist including information of any new medicines prescribed or any changes. Or if the prescription had a CD, or if the person was eligible for any services. Warning laminates were also placed with high-risk drugs and those where pharmacist intervention was required. The ACT checked all prescriptions that had been clinically checked. The RP said he either clinically checked prescriptions before or after they were dispensed depending on the workload. The RP tried to avoid self-checking where possible and had a note up to remind him not to do so. On occasions where he had no option but to self-check he described taking a mental break in between dispensing and checking.

When medicines which looked alike or sounded alike (LASA) were dispensed, dispensers read the product name aloud when picking stock and marked this on the PIF. The PIF was then ticked when it was dispensed and signed when the RP checked. Head office had identified a list of LASA medicines and lists were stuck on each workstation to prompt the team. The team had also attached 'handle with care' labels near areas where they had identified that the team made errors. This included near ramipril capsule and tablets and gentamicin hydrocortisone drops were highlighted to differentiate them from gentamicin.

A quad stamp was used which was initialled by all members of the team to create an audit trail for each stage of the dispensing and supply processes. Dispensed and checked by boxes on labels were also initialled by members of the team. The pharmacy team also used baskets to ensure that people's prescriptions were separated.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The pharmacy had the 'Prevent' pack available and the RP was aware of the need to use the warning stickers. The RP said he had held consultations with people who fell in the at-risk group and regularly collected their medicines from the pharmacy. The pharmacy had completed the audit and the RP said that he had made the team aware of the change in guidance particularly the different pharmacists who worked there and the ACT. The RP had stuck a 'think audit' sign on the wall to prompt the team at the point of checking.

When dispensing other high-risk medications, the RP and dispenser said that the warning cards were used. And these had prompts on the back relating to the questions that needed to be asked or information that needed to be passed on. Insulin was shown to people before being handed out. For warfarin prescriptions the RP checked the yellow book but said that his main concern was to look at what was dispensed and make sure that the tablets supplied matched with the dosage that the person needed to take. INR results were not always recorded on the patient medication record (PMR) for people who were regularly taking warfarin.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Individual record sheets were in place for each person. Prescriptions were usually ordered a week in advance. Red trays were used to store prescriptions for which there were queries. Prescriptions were checked against the individual record and any missing items or changes were chased up and confirmed with a note made on the individual record. Prescriptions were labelled and stock was collected after which it was clinically checked. Packs were then prepared and sealed after which they were checked by the RP or ACT. Hospital discharge summaries were received when people were admitted to hospital; these were stored in the person's file. Some packs were dispensed at a hub store, consent was gained from people prior to this happening.

Assembled packs observed were labelled with product descriptions, mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly. Deliveries were carried out by drivers who were based at a hub. People were called prior to arranging delivery. The delivery driver used an electronic device to obtain signatures when medicines were delivered. In the event that the medication could not be delivered it was returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs and those requiring cold storage. Fridge temperatures were monitored and recorded daily, and these were observed to be within range. CDs were kept securely. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The RP said that the

store was due to go live on the new system in August after which FMD would be available to be used in store.

Stock was date checked by the dispensers. Sections were checked on a weekly basis with the whole dispensary completed over 13 weeks. Stock going out of date was highlighted with a short-dated sticker, recorded and removed. There were no date expired medicines found on the shelves sampled. A date checking matrix was in place.

Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors. Drug recalls were received via alerts from Boots Live. The RP printed these out and left them for the team to see. In the absence of the RP it was sometimes a problem to action the alerts on the system. One of the dispensers had the access to view the alerts but was unable to access the system to update the action taken. The RPs line manager usually called the pharmacy when he was away to check if any alerts had been actioned by the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. A separate counter was used for cytotoxic medication to avoid contamination.

Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork/dispensing labels were collected in blue confidential waste bags and then sent to head office for destruction.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.